Printed: 08/16/2013 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER		1` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		175499		B. WING		08/16/2013	
	OVIDER OR SUPPLIER N GARDENS OF PRA	IRIE VILLAGE	7105 MIS	SSS, CITY, STATE SION ROAD VILLAGE, K			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY F R LSC IDENTIFYING INFORMAT	ULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFIDERICENCY)	D BE COMPLET	TION
F 000	The following citations represent the findings of a			F 000			
	Health Resurvey. 483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally			F 156			
	The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing.						
	The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the		e time the e ng se rs and de to hs				
LABORATOR	facility and of charges including any charges under Medicare or by		ed rate.		TITLE	(X6) DATE	

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

NAME OF PROVIDER OR SUPPLIER BRIGHTON GARDENS OF PRAIRIE VILLAGE (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 156 Continued From page 1 The facility must furnish a written description of legal rights which includes: D PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) D PREFIX TAG F 156 The facility must furnish a written description of legal rights which includes:	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER (X1) PROVIDER/SUPPLI		LIA		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
BRIGHTON GARDENS OF PRAIRIE VILLAGE (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) F 156 Continued From page 1 The facility must furnish a written description of T105 MISSION ROAD PRAIRIE VILLAGE, KS 66208 ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 156 The facility must furnish a written description of			175499		B. WING		08/16/2013		
PRAIRIE VILLAGE, KS 66208 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 156 Continued From page 1 The facility must furnish a written description of									
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 156 Continued From page 1 The facility must furnish a written description of	BRIGHTO	N GARDENS OF PRA	AIRIE VILLAGE						
The facility must furnish a written description of	PRÉFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY F	ULL	PREFIX	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO	LD BE	COMPLETION	
A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalization spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to	F 156	The facility must furn legal rights which in a A description of the repersonal funds, under section; A description of the refor establishing eligible the right to request a 1924(c) which detern non-exempt resource institutionalization and spouse an equitable cannot be considered toward the cost of the medical care in his of down to Medicaid eligible. A posting of names, numbers of all perting groups such as the Sagency, the State lice ombudsman program advocacy network, a unit; and a statement complaint with the Stagency concerning remisappropriation of refacility, and non-compliant with the Stagency concerning remisappropriation of refacility, and non-compliant with the Stagency concerning remisappropriation of refacility must information, a applicants for admissing information about how the section of the section of the facility must program advocacy network, and physician responsible.	nish a written description cludes: manner of protecting er paragraph (c) of this requirements and proce polity for Medicaid, included an assessment under semines the extent of a coles at the time of and attributes to the community of the process of spending gibility levels. addresses, and telephole ent State client advocate state survey and certificate survey and certificate ensure office, the State on, the protection and and the Medicaid fraud of the that the resident may that the survey and certificate survey and certificate ensure office, the State on the Medicaid fraud of the that the resident may that the survey and certificate survey and certificate sident abuse, neglect, resident property in the appliance with the advancents. Form each resident of the laway of contacting the efor his or her care. In the provident of the state of the polity of the contacting the efor his or her care.	dures ding ection uple's munity ch se's ng ane cy ation file a tion and ce acility and	F 156				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		175499		B. WING		08/1	6/2013
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	RESS, CITY, STA	TE, ZIP CODE	•	
BRIGHTO	N GARDENS OF PRA	IRIE VILLAGE		SSION ROA E VILLAGE,			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY F LSC IDENTIFYING INFORMAT	ULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 156	Continued From pag	e 2		F 156			
	receive refunds for previous payments covered by such benefits.						
	The facility reported at Three residents were notice of non-coverage and interview, the fact residents of services and #7) records revie	not met as evidenced be a census of 33 residents reviewed for medicare ge. Based on record revility failed to inform the ending for 3 of 3 (#51, swed.	view				
	Findings included:						
	- Review of Medicare A notice of non-coverage for resident #51 revealed the notice lacked a patient number and failed to inform the resident/representative, of the type of Medicare services that were ending.						
		d not identify the reside nor the type of medicar					
	The facility failed to provide a complete medicare notice of non-coverage to include the type of medicare services ending and the resident's identification number.						
	for resident #59 revea patient number and fa	e, of the type of Medic	1				
	Interview on 8/13/13 a confirmed the form di	at 2:45 P.M. staff HH d not identify the reside	ent's				

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		175499		B. WING		08/10	6/2013
	OVIDER OR SUPPLIER N GARDENS OF PRA	IRIE VILLAGE		ESS, CITY, STA SSION ROA VILLAGE,	ND.		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY F LSC IDENTIFYING INFORMAT	ULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 156	The facility failed to p notice of non-coverage medicare services en identification number. Review of Medicare for resident #7 reveal patient number and faresident/representatives services that were en Interview on 8/13/13 a confirmed the form di identification number services that were distributed for non-coverage medicare services en identification number. 483.10(g)(1) RIGHT READILY ACCESSIE A resident has the right the most recent surve by Federal or State significant correction in effect with the facility must make examination and must recent surves the facility must make examination and must recent surves the facility must make examination and must recent surves the facility must make examination and must recent surves the facility must make the right facility must make examination and must recent surves the facility must make the right facility faci	nor the type of medical scontinued. rovide a complete medige to include the type or ding and the resident's e. A notice of non-coveried the notice lacked a sailed to inform the eye, of the type of Medical ding. at 2:45 P.M. staff HH d not identify the resident nor the type of medical scontinued. rovide a complete medige to include the type of ding and the resident's	icare f age are ent's re icare f s - its of ted of /	F 156			

This Requirement is not met as evidenced by:

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/ AND PLAN OF CORRECTION IDENTIFICATION NUMB				CONSTRUCTION	` '	(X3) DATE SURVEY COMPLETED	
		175499	1	B. WING		08	/16/2013
NAME OF PR	OVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STATI	E, ZIP CODE	•	
BRIGHTO	N GARDENS OF P	RAIRIE VILLAGE		IISSION ROAD IE VILLAGE, K			
(X4) ID PREFIX TAG	(EACH DEFIC	Y STATEMENT OF DEFICIENCIE ENCY MUST BE PRECEDED BY OR LSC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 167	The facility identification and in provide the most of federal and state is correction in a rearesidents and visit the survey. Findings included: On 8-8-13 at 9:2 station documents available to review stated the survey station, they were office on the assis and you had to as On 8-14-13 at app #26 stated he/she survey results were on 8-14-13 at app administrative staff have a policy for segulatory guideling. The facility failed the federal and state is visitors. 483.15(b) SELF-D	ed a census of 33 resided led 18 residents. Based of the leterview the facility failed ecent survey results of the survey with the plan of dily accessible area for ors on 1 of 4 days onsite and the latest survey results. At that time licensed not results were not at the nut located in the administrated living side of the facility is to review the results. It is recommately 3:30 P.M. resides and aware of what the or where they were locations and followed the results and followed.	es' s were urse N irses' tion ity, ident ne ated.	F 167			
	schedules, and he her interests, asse interact with meml inside and outside	he right to choose activities that care consistent with essments, and plans of capers of the community bothe facility; and make chais or her life in the facility	his or are; th oices				

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING CO	
175499 B. WING	20/40/0040
	08/16/2013
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
BRIGHTON GARDENS OF PRAIRIE VILLAGE 7105 MISSION ROAD PRAIRIE VILLAGE, KS 66208	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 242 Continued From page 5 F 242	
are significant to the resident. This Requirement is not met as evidenced by: The facility identified a census of 33 residents. The sample included 18 residents of which 3 were reviewed for choices. Based on observation, interview, and record review the facility failed to provide choices and preferences for one resident regarding bedtime, (#48) and bathing choices for one resident (#85). Findings included: Resident #48's admission Minimum Data Set 3.0 Assessment (MDS) dated 7-6-13 documented the resident's Brief Interview for Mental Status Score of 12 which indicated the resident had moderately impaired cognition. The resident required extensive assistance with activities of daily living (ADLs) for bed mobility, transfers, locomotion on and off unit, dressing, tollet use, and personal hygiene. The MDS documented it was very important for the resident to choose his/her own bedtime. Review of the 8-13-13 care plan lacked documentation of the resident's choices and preferences. Observation on 8-12-13 at 4:35 P.M. revealed the resident sat in his/her wheelchair in his/her room with the TV on. On 8-8-13 at 11:27 A.M. during an interview with the resident, he/she stated he/she liked to go to bed around 11:00 P.M. or around midnight, but staff informed him/her, he/she had to go to bed by 10:00 P.M.	

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NAME OF PR	OVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE	<u> </u>	
BRIGHTO	N GARDENS OF PRA	IRIE VILLAGE		ISSION ROA E VILLAGE,			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FILSC IDENTIFYING INFORMAT	ULL	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 242	On 8-13-13 at 4:08 P. he/she asked the resign to bed during the ethe resident wanted to On 8-14-13 at 7:04 A. the resident was in beduty at 10:00 P.M. On 8-14-13 at 11:41 A acknowledged the reschoices were not doctorare. On 8-14-13 at 1:17 P. the certified nursing a made aware of the repreferences from the updated the CNAs with residents. The facility failed to prehict of bedtime. The Minimum Data admission assessment resident #85 required staff for bathing. The Care Area Assess of Daily Living (ADL) or resident required helphad a recent CVA (ceevent that affects men and a decline in his/hed He/she also had impafunction) which could activities of daily living the country and the could activities of daily living the country and the could activities of the country and the count	a.M. direct care staff U s dent when he/she want evening and was not averaged and was up later. A.M. licensed staff BB stable when he/she came of the plan and the nurse sidents' choices and care plan and the nurse the any changes for the the plan of the plan and plan accidental and physical abilities are functional mobility. A plan and the plan and plan accidental and physical abilities are functional mobility. The plan are the plan and plan accidental and physical abilities are functional mobility. The plan are the plan and plan accidental and physical abilities are functional mobility. The plan are the plan and the plan are the plan are the plan and the plan are the plan and the plan are the plan and the plan are the p	ted to vare ated on ff HH d ated es ther the ated es ther the ated es the ate	F 242			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	LE CONSTRUCTION	, ,	(X3) DATE SURVEY COMPLETED	
		175499		B. WING		08/1	6/2013	
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDR	RESS, CITY, STA	TE, ZIP CODE			
BRIGHT	ON GARDENS OF PRA	IRIE VILLAGE		MISSION ROAD RIE VILLAGE, KS 66208				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY F LSC IDENTIFYING INFORMAT	ULL	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE LE APPROPRIATE	(X5) COMPLETION DATE	
F 242	resident took a showed Wednesday, after lunbed. He/she required assistance for bathing assistance. Observation on 8/12/laid in bed sleeping. A was in his/her room in speech therapist presson as leep with the bed in The clinical record lad or the type of bath the Interview on 8/12/13 at the resident was unawareceived baths. The bath sometimes in the night, and sometimes least 2 baths a week. Interview on 8/12/13 adirect care staff O state were Monday day shith He/she gave the resident was unawared to a staff of the sta	er with the preferred dach, before dinner, or be extensive to total g with 1 to 2 person phy 13 at 1:30 P.M. the resident 4:30 P.M. the resident the wheelchair with the tent. M. the resident laid in the the low position. Cked documentation of the resident received. At approximately 10:15 ware of what days he/s resident stated I receive the morning sometimes in a not at all. I would like a state of the resident's bath fit and Thursday 2 to 10 at 10 a	efore /sical ident int ie ped A.M. he e a in the at P.M. days o shift. prked. e staff en I and y fill sue. th	F 242				

		(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMB		A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		175499)	B. WING		08	/16/2013
NAME OF PR	OVIDER OR SUPPLIER	•	STREET ADD	RESS, CITY, STATE	, ZIP CODE	•	
BRIGHTO	N GARDENS OF P	RAIRIE VILLAGE		IISSION ROAD IE VILLAGE, K	S 66208		
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIE ENCY MUST BE PRECEDED BY OR LSC IDENTIFYING INFORM/	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 242	that we took care of Review of the cert flow sheet provide for residents were this sheet, baths for Monday evenings. Interview on 8/14/1 administrative nurs was not aware the and believed he/sl shower 2 times. Acconfirmed there wishowers the reside	or the resident for the shirt ified nurse assistant same down the facility revealed scheduled by rooms, and or this resident were lister and Saturday mornings. 13 at 5:25 P.M. with sing staff D revealed he/s resident received bed be a saw the resident get a dministrative nursing staff as no documentation of cent received, and the care showers a week on a correction of the care showers a week on a correction.	ple baths d per d as she aths, f D	F 242			
F 279 SS=D	The facility failed to provide the resident a choi of bathing on a consistent basis. 483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS			F 279			
A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident' highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided.		care rable nt's ocial sive nat are ident's					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	1, ,	(X3) DATE SURVEY COMPLETED	
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		175499		B. WING		08/1	6/2013	
	OVIDER OR SUPPLIER			RESS, CITY, STA				
BRIGHTO	N GARDENS OF PRA	IRIE VILLAGE		SSION ROA E VILLAGE,				
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F 279	Continued From page	e 9		F 279				
1 219	Continued From page 9 due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).			1 213				
	The facility identified a The sample included observation, interview facility failed to develo	not met as evidenced bacensus of 33 resident 18 residents. Based or and record review, the pan individualized car resident of the sample	ts. 1 e					
	Findings included:							
		imum Data Set 3.0 dat dent #85 required total taff for bathing.						
	daily living dated 7/25 required help with his (ADLs). He/she had a vascular accident, an and physical abilities) functional mobility. He cognition, (poor mental)	ssment (CAA) for activit 5/13 listed the resident /her activities of daily linarecent CVA (cerebral event that affects menda, and a decline in his/hie/she also had impaired al function) which could with (ADL) performance.	ving tal er d					
	resident took a showed Wednesday, after lunbed. He/she required for bathing with 1 to 2 Observation on 8/12/2 laid in bed sleeping. A was in his/her room in	7/18/13 for bathing lister with the preferred dach, before dinner, or be extensive, total assistate person physical assistant 13 at 1:30 P.M. the resider At 4:30 P.M. the resider at the wheelchair with the president at the wheelchair with the resider at the res	y of efore ance cance.					
	speech therapist pres	ent.						

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		175499		B. WING		08/16/2013	
NAME OF PR	OVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE	-	
BRIGHTO	N GARDENS OF PRA	IRIE VILLAGE		ISSION ROA E VILLAGE,			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY F LSC IDENTIFYING INFORMAT	ULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 279	On 8/13/13 at 7:10 A. asleep, with the bed in The clinical record lad or the type of baths the Interview on 8/12/13 arevealed the resident he/she received baths received a bath some sometimes in the night would like at least 2 b. Interview on 8/12/13 addirect care staff O state were Monday day shirt I gave the resident at work. Interview on 8/14/13 a staff CC stated I gave Saturdays in the morn cannot sit up straight the shower. Direct caresidents bath days we Saturday mornings. Review of the sample (CNA) flow sheet provibaths for residents we and per this sheet, bath listed as Monday ever mornings. Interview on 8/14/13 a administrative nursing plan should address to the sample for the sample of the samp	M. the resident laid in to the low position. cked documentation of the resident received. at approximately 10:15 to was unaware of what is, the resident stated I etimes in the morning, into, sometimes not at allustrates a week. at approximately 3:30 Foot ted the resident's bath of the approximately 3:30 Foot ted the resident's bath of the approximately 3:30 Foot ted the resident a bed bath on the Thursday 2-10 bed bath on the Thursday 2-10 bed bath on the Thursday and he/she was not sairly staff CC stated the vere Monday evenings are staff CC stated the vere Monday evenings are scheduled by rooms at the for this resident we mings and Saturday at 5:25 P.M. with graph of the 2 showers a week. evelop an accurate	when A.M. days . I P.M. days shift. lays I care h on ne fe in and nt ealed s, ere	F 279			
	individualized care pla	an for this resident for					

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(X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING _ COMPLETED 175499 B. WING 08/16/2013 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **BRIGHTON GARDENS OF PRAIRIE VILLAGE** 7105 MISSION ROAD PRAIRIE VILLAGE, KS 66208 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 279 F 279 Continued From page 11 bathing. F 280 483.20(d)(3), 483.10(k)(2) RIGHT TO F 280 SS=E PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This Requirement is not met as evidenced by: The facility identified a census of 33 residents. The sample included 18 residents. Based on observation, interview, and record review the facility failed to review and revise the care plan for 4 of 18 residents (#31, #48, #5, #70) to include changes in care and failed to invite resident #48 to his/her care planning meeting. Findings included: - Resident #31's quarterly Minimum Data Set 3.0 Assessment (MDS) dated 6-19-13 documented the resident's Brief Interview for Mental Status

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NAME OF PR	OVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE	•		
BRIGHTO	N GARDENS OF PRA	IRIE VILLAGE		SSION ROA E VILLAGE,				
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F 280	Score (BIMS) of 12, with moderately imparequired extensive as activities of daily livin limited assistance wit toilet use. The reside staff for personal hygmobility. The MDS do displayed verbal beh seven day assessme to 3 days of seven da	which indicated the residered cognition. The resident required supervision giene, eating, and bed ocumented the resident eaviors 1 to 3 days of the ent period and rejected cay assessment period. The Area Assessment (Comented the resident recident recident recident recident period and rejected of any assessment period. The Area Assessment (Comented the resident recident recident recident recident recident period and rejected of any assessment period. The resident with zation, panic attacks, and the resident was impured to the resident was impured to the resident was impured reality orientation in directed staff to speak in the resident was obsessed oxygen. The care plan and the resident to call for the pick and the resident reveals air Diskus (a medication reveals	ident in, ind in of ecare 1 CAA) eived and ind ent eased ulsive, usive at to are d with or	F 280				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		175499		B. WING		08/10	6/2013
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	ESS, CITY, STA	ATE, ZIP CODE	•	
BRIGHTO	N GARDENS OF PRA	IRIE VILLAGE		SSION ROA E VILLAGE,			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETION DATE
F 280	medication) three time anxiety, Seroquel (an three times daily, and to treat lung disorders air) inhaler as needed. The 7-12-13 Psychiatresident with some imbehaviors. The 5-29-13 interdisc time written, documenten urses' station musured the nurses' station musured the nurses' station musured the psychotic behavior the a gerontology (eld). The 5-31-13 ID note with the psychotic behavior to inform them when the tantrums. The physication to inform them when the tantrums. The physication to seroquel, became disyelled and asked for the resident was hateful a staff. On 8-7-13 with no time documented staff notion the resident's belliger behaviors. The residentes and the resident was the resident to the resident that the reside	es daily and as needed anti-psychotic medical Proair (a medication of the that caused shortness of for shortness of air. Aric exam documented the provement of his/her diplinary note (ID) with monted the resident came altiple times during the rinhaler and the resident continued to bors, he/she would be rederly) psychiatric unit. With no time written, dent's family requested the resident had tempe being prescribed Seroque and ID note entered 17-31-13 documented to receive Buspar and suruptive at times, screanis/her inhalers. The land inappropriate toward the resident's family requested the resident's family requested the resident Seroque and suruptive at times, screanis/her inhalers. The land inappropriate toward the written, the ID note iffied the resident's family requested the resident's family rent demanded his/her got reatments. Staff gave the treatments but the	tion) used s of the no to day ent have ferred staff er el for the med, rd	F 280			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
	17549			B. WING		08/16/2013	
		170400				08/1	6/2013
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BRIGHTO	N GARDENS OF PRA	IRIE VILLAGE		SSION ROA E VILLAGE,			
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F 280	Continued From page	e 14		F 280			
	documented the resident had anxiety and his/her verbal aggression escalated.						
	On 8-9-13 at 5:35 P.M. the ID note documented staff obtained an order to increase the resident's Buspar dosage for his/her increased behaviors.						
	Observation on 8-12-13 at 4:34 P.M. revealed the resident sat in his/her wheelchair in activity room with other residents and staff and no behaviors exhibited.						
	Observation on 8-13-13 at 8:30 A.M. revealed the resident in the dining room for the breakfast meal with other residents and staff and no behaviors exhibited.						
	On 8-13-13 at 4:08 P.M. direct care staff U stated the resident had behaviors when he/she had difficulty with breathing and he/she would yell and curse staff. Direct care staff U stated when the resident had behaviors, staff left and came back later.						
	stated the resident did his/her room, had a lo apologize after displa staff Q stated the resi because he/she thoug	A.M. direct care staff Q d not like 2 people ente of of behaviors and wou ying behaviors. Direct dent became anxious ght something was wroudent screamed through	old care ng.				
	stated staff redirected resident in a calm ma interaction, and redire acknowledged the ca	A.M. social services start the resident, spoke to inner, provided one to cected the resident. He/s re plan lacked the special social services for the behaviors	the one she sific				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE			LE CONSTRUCTION	(X3) DATE SU COMPLET	
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	OVIDER OR SUPPLIER N GARDENS OF PRA	IRIE VILLAGE	7105 MI	RESS, CITY, STA SSION ROA E VILLAGE,	D		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY F LSC IDENTIFYING INFORMAT	ULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 280	he/she was not certain resident's behaviors at panic attack, the resident respond fast enough. The resident and gave the wanted without convert upset the resident. The facility failed to replan that addressed the behaviors and specific behaviors. - Resident #48's adm 3.0 Assessment (MD) the resident's Brief In Score of 12 which incommoderately impaired required extensive as	in what triggered the and when the resident had the staff did not. He/she stated staff trie, did not argue with the eresident what he/she ersation because that a eview and revise the cather esident's specific ic interventions for the mission Minimum Data SS) dated 7-6-13 docum terview for Mental Stated the resident had cognition. The resident	nad a ed to lso are Set ented us	F 280			
	transfers, locomotion toilet use, and person The 8-11-13 care plan was on a fluid restrict information regarding was allowed and lack distributed fluids through resident. Review of the staff invited the reside Attorney (DPOA) to homotion to the reside the resident the reside the resident th	on and off unit, dressing	dent ked sident taff dence ver of				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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F 280 Continued From page 1	16		F 280				
Record review revealed the facility on 6-29-13. The vidence staff monitored restriction per the physical restriction per the physical Review of the residents staff invited the resident comprehensive care plant observation on 8-13-13 resident in the dining roomesident a cup of coffee, and water. On 8-13-13 at 1:30 P.M. recall staff inviting him/hand stated he/she directed on 8-14-13 at 9:23 A.M. acknowledged the resident whospital several times are a care plan meeting for home of the care plant of the care plan	the resident admitted. The record lacked of the resident's fluid cian's order on 7-31-7 record lacked evident to attend his/her an meeting. The resident did not a glass of milk, juice of the resident did not her to a care plan meeting ted his/her own care. Social services staff fent did not have a DF was in and out of the not staff did not sched him/her. M. social services staff ent did not sched him/her. M. social services staplan lacked intervent ent's fluid restriction. The wand revise the care on of fluid related to the nand failed to invite the care plan meeting. The Data Set (MDS) 3.0 ant #5 revealed a Brief tus score of 5 (severe the resident required)	ance and the					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/G IDENTIFICATION NUMB			LE CONSTRUCTION	(X3) DATE S COMPLE	
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F 280	The revised care planutrition, and oral careceived a regular of nutrition program (Sweigh the resident vand registered dietitior gain. The resider received a supplem was offered a snack encourage the resident wished to and as maresident was at risk diagnosis of failure loss). The resident with breakfast and owhen available. The care plan lacked observation and into set up assist with mare the resident's food, sat down beside the her/him with eating, behind the resident. Observation on 8/8/visitor of another rethe resident's food, sat down beside the her/him with eating, behind the resident. Observation on 8/13 resident's durable p stated she/he came resident ate and recident are and recident ate and recident are and recident at a supplementation of the came resident at a and recident are and recident at a supplementation of the came resident at a and recident are and recident at a supplementation of the came resident at a and recident are and recident at a supplementation of the came resident at a and recident at a supplementation of the came resident at a supp	an dated 6/17/13 for dinitian and dated 6/17/13 for dinitian are revealed the resident are revealed the resident diet and was on the specific solution. Nursing staff would weekly and notify the physican of significant weight at liked coffee at meals, ent daily with noon meals at night. Nursing staff valent to finish her/his meadent usually refused offer the could eat what she/he uch as she/he wished. The for weight loss due to a to thrive (inappropriate valent would receive super cerebranberry juice twice a did documentation from the erview the resident require als. 13 at 12:53 P.M. revealed and assisted in cutting and different visitor shortly the resident and assisted a	t dial dial dial dial dial dial dial dial	F 280			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 280	Continued From page	ge 18		F 280		
	staff O stated the reswith cutting up food and interview on 8/14/13 staff R stated the respective resident with noon massistance with cutting constant cueing. Interview on 8/14/13 nursing staff L stated she/he required staff DPOA came daily to	at 4:06 P.M. with direct sident required assistant and assistance with mean at 1:54 P.M. with direct sident's DPOA assisted neals. The resident required at 12:19 P.M. with licer at the resident had days f assistance with meals. The replans to reflect a resident at 12:10 P.M. with licer at the resident had days f assistance with meals.	ce als. care the ired ad sed when The sing			
	Interview on 8/14/13 administrative nursin staff updated the car activity of daily living	ng staff D stated the nurse re plans to reflect a residenceds. revise/update the reside rident who required	dent's			
	resident #70 docume dementia with psych disorder characterize confusion with any n	Physician's Order Sheet ented a diagnosis of osis (a progressive mer ed by failing memory an najor mental disorder ross impairment in reali	ntal d			
	_	nge Minimum Data Set 3 ed a Brief Interview for M				

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C		1 1	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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	Status score of 1 (les impaired cognition). Review of this resider 2:00 P.M. dated 4/24/this resident needed at to discontinue the plate further warranted. Interview on 8/14/13 and nursing staff J stated for updating the informal interview on 8/14/13 administrative nursing were responsible for uneeded. The facility policy "Sk Care & Service Plans failed to address the plans. The facility failed to rethis resident's assistive 483.25 PROVIDE CA HIGHEST WELL BEIL Each resident must reprovide the necessary or maintain the highermental, and psychosol	s than 7 indicated several section of the care plan on 8/13/1/13 for nutrition docume a plate guard at all measured 8/13/13 recommend the guard as it was not at 9:30 A.M. licensed the nurses were respondition on the care plans at 3:00 P.M. with gestaff D stated the nursupdating the care plans willed Nursing Individual Standards of Performan process for updating the evise the care plan to reve devices. RE/SERVICES FOR NG Receive and the facility in y care and services to a st practicable physical,	3 at ented als. ded nsible as. ses sas ized nce" e effect	F 309			
	This Requirement is	not met as evidenced b	ov:				

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		1 ' '	LE CONSTRUCTION	(X3) DATE SUR COMPLETE	
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F 309	The facility reported at The sample included observation, record refacility failed to invest origins for 1 (#17) rest the physician's orders (#48) resident in the state of the physician's orders (#48) resident in the state of the physician's orders (#48) resident in the state of the physician's orders (#48) resident in the state of the physician's orders (#48) resident #1 (#10) for resident #1 (#10) for resident #1 (#10) for resident #1 (#10) for resident for mobility, transfers, was room/corridor, locomod dressing, toilet use, post bathing. The resident required stabilization moving from seated the walking, turning around toilet, and surface-to resident did not have upper/lower extremition wheelchair for mobility. The revised care plan revealed nursing staff skin assessment and skin issues. The certification would observe and resident by (x) 6 inches) on the resident's family memory family memory family memory family family memory family family memory family family family memory family f	a census of 33 residents 18 residents. Based or eview, and interviews, to igate bruising of unknowident, and failed to folkes for fluid restriction for sample. In Data Set (MDS) 3.0 and 17 revealed a Brief Status score of 4 (sever and the resident required of one person for bed alking in her/his obtion on/off the unit, the ersonal hygiene, and was not steady and with staff assistance who a standing position, and, moving on and off the surface transfer. The impairment to the est, and used a walker and used 8/3/13 at 10:20 P.I. and a large bruise (5 in the resident did not keep th	he wn bw 1 dated re hen he and sly any) M. nches and the dithe	F 309			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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F 309	Continued From page	e 21		F 309			
	resident stated the bro	uised area did not hurt.					
	Observation on 8/8/13 at 12:50 P.M. revealed the resident had a large bruise on the right wrist.						
	Observation on 8/12/13 at 2:15 P.M. revealed the resident had a large bruise on the left forearm and right hand.						
	Record review on 8/14/13 at 10:00 A.M. lacked documentation of an investigation for bruising of unknown origins.						
	Interview on 8/12/13 a resident stated she/he obtained the bruises.	at 2:17 P.M. with the e was not sure how she	e/he				
	staff Q stated she/he obtained the bruises.	at 4:20 P.M. with direct did know how the resid She/he would notify the bruising on a resident.	lent				
	nursing staff J stated	at 9:16 A.M. with licens nursing staff document ' notes and staff would n form.					
	unable to find any doo of the resident's bruis	at 9:23 A.M. with g staff D stated she/he comentation for investiging. Nursing staff shoule the resident's bruises.	gation d				
	nursing staff L stated	at 12:19 P.M. with licen nursing staff would initi for bruises of unknown	iate				
	Interview on 8/14/13 a administrative staff A	at 10:00 A.M. with stated she/he could no	t find				

		(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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F 309	Continued From page	e 22		F 309			
	any investigation docubruising.	umentation for the resid	dent's				
	The facility failed to investigate bruising of unknown origins for this cognitively impaired resident.						
	- Resident #48's admission Minimum Data Set 3.0 Assessment (MDS) dated 7-6-13 documented the resident's Brief Interview for Mental Status Score of 12 which indicated the resident had moderately impaired cognition. The resident required extensive assistance of staff with activities of daily living (ADLs) for bed mobility, transfers, locomotion on and off unit, dressing, toilet use, and personal hygiene.						
	The 8-11-13 care plan documented the resident was on a fluid restriction. The care plan lacked information regarding how much fluid the resident was allowed and lacked interventions how staff distributed fluids throughout the day for the resident.						
	fluid restriction of 2 lite period and directed st	ent's cardiologist ordere ers (64 ounces) in a 24 aff to weigh the resider she went to the bathroo e breakfast.	hour nt in				
	note documented the facility from a physician physician ordered dai and notify him/her if the pounds in 3-5 days. Testriction of no more	M. the interdisciplinary resident returned to the an's appointment. The ly weights for the resident gained 3-5. The physician ordered than 2 liters (64 ounce, and elevate the residents)	ent fluid s) in				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		1 1	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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F 309	Continued From page	e 23		F 309			
	legs as much as poss						
	(MAR) documented the medication that excress milligrams (mg) daily or more pounds of flustesident and extra 20. The resident's record monitored the resident.	lacked evidence staff nt's fluid restriction. documented the resident 8-6-13 and returned the resident start and returned the resident's days for August 2013:	six (a) 60 ed 2 /e the				
	8-7 - in hospital						
	8-8 - no weight docun 8-9 - no weight docun 8-10 - 208 lbs 8-11 - 209.4 lbs 8-12 - 205.6 lbs 8-13 - no weight docu	mentedumented					
	was on a 2 liter fluid r visits to the wound cli of the wounds on his/	dent saw the physician a restriction and had weel inic for aggressive treat ther feet.	kly ment				
	services staff HH ack	timately 1:50 P.M. social nowledged the resident notation of the resident's	t's				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		, ,	(X3) DATE SURVEY COMPLETED	
		175499		B. WING	<u>.</u>	08.	/16/2013	
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weight or staff R if 8-13 and paper fro resident's 221.8 lbs recorded that time. On 8-14-the resident treatmen resident's 8-14-13. Observat resident is resident and water on treatment resident and water on 8-14-were not restriction licensed order for have a plaintake. On 8-14-acknowled August 8 He/she a increase re-weight the resident is resident and water order for have a plaintake.	he/she had to 8-14-13. Did in his/her possible to not 8-14-13. The weights on 8-14-13. The weights on 8-8 or 8-8 or 8-8 or 8-8 or 8-9 or 8-8 or 8-9 or 8-13 in the dining a cup of coffer. 13 at 12:15 aware the real of the reviestaff J acknowledge on the 13th and 9th and cknowledge on the 13th and 9th	dates and asked direct the resident's weights for irect care staff R pulled ocket and stated the 3-13-13 was 218.2 lbs at a Social Services staff I on the resident's MAR dimately 2:00 P.M. reviewall lacked evidence staff at they did not weigh the 3-13 or provide medication notify the physician of weight gain for 8-13 or weight gain for 8-13 or and staff served fee, a glass of milk, juiced at the served the physician of the resident's recombined and staff served from and staff served from and staff served from and stated they did from and stated they did from the 13th and 14th. In the substantial weight and 14th and staff should the substantial weight and 14th. The she stated the night assistants (CNAs) weight assistants (CNAs) weight and 14th and 14th.	or a and HH at at ew of ion f the ed the the ee, and d d d d d d d d d d d d d d d d d d	F 309				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1` ′	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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F 309	Continued From page	e 25		F 309				
	_	nonitor the resident's fluor weigh the resident date						
	483.25(h) FREE OF A HAZARDS/SUPERVI			F 323				
	as is possible; and ea	as free of accident haz						
	This Requirement is not met as evidenced by: The facility identified a census of 33 residents. The sample included 18 residents. Based on observation, interview, and record review the facility failed to investigate 3 of 5 falls for 1 (#17) of 4 residents sampled for falls, and failed to lock the 2 doors of one of 3 prep kitchen in which a stream table contained 4 wells that contain hot water for 1 of 4 days of survey.		ts. 1 e #17) lock					
	Findings included:							
	dietary staff DD enter on the long term care kitchen revealed stea and steam rising from was tempted by dieta degrees Fahrenheit (I dining room was unlo in the dining room.	/13 at 9:20 A.M. revealed an unlocked prep ki unit. The unattended pm table wells uncovered the wells. The hot watery staff DD which read F). The door to the adjooked and 4 residents wet 9:30 A.M. with dietary	tchen orep ed ter 132.8 ining vere					
		t 9:30 A.M. with dietary tchen door was never	stall					

		(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE	LIA		ELE CONSTRUCTION	' '	(X3) DATE SURVEY COMPLETED	
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NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	RESS, CITY, STA	ATE, ZIP CODE	•		
BRIGHTO	N GARDENS OF PRA	IRIE VILLAGE		SSION ROA E VILLAGE,				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY F LSC IDENTIFYING INFORMAT	ULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 323	Continued From page	e 26		F 323				
	locked and the steam off.	ı table was recently turr	ned					
	On 8/8/13 at 9:40 A.M. the steam table wells were re-tempted with surveyor LL with two different thermometers which read 131.5 F and 131.1 F.							
	Interview on 8/8/13 at 9:45 A.M. dietary staff DD and administrative nursing staff D acknowledge the temperatures and the potential hazard to residents.							
	nursing staff D identif	t 10:15 A.M. administra ied 7 independently nobile residents on the						
		rovide a safe and haza the long term care unit v mobile residents.						
	- The signed Physician's Order Sheet (POS) dated 4/24/13 for resident #17 revealed a diagnosis of right femur fracture (broken right hip).		·					
	6/19/13 revealed a Bri Status score of 4 (sex The resident required one person for bed m her/his room/corridor, dressing, toilet use, p bathing. The resident stabilization with staff from seated to standing around, moving on ar	was not steady and ne assistance with moving ng position, walking, tu	od). of og in unit, eeded g rning					

AND PLAN OF CORRECTION IDENTIFICATION NUM		(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		1 ' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		175499		B. WING		08/16/2013	
NAME OF PR	OVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
BRIGHTO	N GARDENS OF PRA	IRIE VILLAGE		ISSION ROA E VILLAGE,			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FI LSC IDENTIFYING INFORMAT	ULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE)	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 323	have impairment to hextremities and used mobility. The resident admission/entry or re The Care Area Assess revealed the resident injury and required extransfers, toileting, and Non-skid footwear was prevent slips. Her/his alarms in place to ale remind the resident in The resident's bed was mat was placed beside. The revised care plan revealed a chair/bed nursing staff, bed plan a bedside fall mat, rethe edge of a chair, putherapy, nursing staff with all transfers until safe on her/his own, it assistance of 1 person ensure the resident wout of bed to prevent the resident upon risis meals, and as needed performed monthly and frequently used items. The Skilled Nursing Hevaluation and Assess revealed the resident days, had a history of devices, had unstead (progressive mental country of the confusion and medical progressive mental country of the confusion and the confusion and the confusion and the confusion and t	er/his upper/lower a walker, and wheelchat t had one noninjury fall entry or prior assessme sement dated 5/7/13 for had a history of falls wi ktensive assistance with dactivities of daily livin as worn while out of bed wheelchair and bed ha ert nursing staff and to not to get up without ass as kept in low position a de her/his bed while in the dated 6/24/13 for falls alarm at all times to ale ce in the lowest position positioning when seated whysical and occupation where who as sistent where w	since ent. Falls ith n ng. d to ad sist. and a ped. ert n with d on al nce was while delet fafter was p	F 323			

· '		(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE	/CLIA		2) MULTIPLE CONSTRUCTION BUILDING		(X3) DATE SURVEY COMPLETED	
175499		175499		B. WING		08/1	6/2013	
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	RESS, CITY, STA	TE, ZIP CODE			
BRIGHTO	N GARDENS OF PRA	IRIE VILLAGE		SSION ROA E VILLAGE,				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FI LSC IDENTIFYING INFORMAT	ULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 323	bed/chair alarms and position with a bedsid The Nursing Notes (Nuntimed revealed nursesident slide out of haloor. Record review 8/14/1 documentation of a farm The NN dated 5/12/13 resident was on found the bed. The Fall Investigation revealed the resident interventions were in consisted of a low bed resident was encourad The call light was with The NN dated 5/31/13 certified nursing aide alarm sounding and the crawling on the floor is mat. The bed was at the was in place and the which the resident did not the resident did not the resident's alarm sound staff found the resident the resident's alarm sound staff found the resident the resident the resident's alarm sound staff found the resident the	the bed in the lowest e mat. IN) dated 4/28/13 and sing staff witnessed the er/his wheelchair to the 3 at 7:25 A.M. lacked III investigation. 3 at 11:30 P.M. revealed laying on the fall mat III had a history of falls. Splace at time of fall which and a fall mat. The ged to call for assistancin the resident reach. 3 at 2:01 A.M. revealed (CNA) responded to a line resident was found in her/his room near the the lowest position, flocicall light was within real not use.	d the by 3 safety ch ce. the bed e floor or mat ch d the and sher	F 323				
	Record review 8/14/1	3 at 7:25 A.M. lacked						

			1` '			(X3) DATE SURVEY COMPLETED	
	175499		B. WING		08	/16/2013	
OVIDER OR SUPPLIER		STREET ADDR	RESS, CITY, STATE	E, ZIP CODE			
N GARDENS OF PR	AIRIE VILLAGE						
(EACH DEFICIE	NCY MUST BE PRECEDED BY I	FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION	SHOULD BE	(X5) COMPLETION DATE	
documentation of a The NN 7/24/13 at member found the the fall mat. The beresident stated she wheelchair located The Fall Investigatire vealed the reside interventions were alarm, bed in low printervention was to all times. Observation on 8/1 resident layed in a was within reach are observation on 8/1 resident slept in a lewithin reach, a fall in and a bed alarm attraction on 8/1 resident sat in the a chair alarm on. Interview on 8/14/1 staff W stated the convertion forms Interview on 8/13/1 nursing staff H state completed a fall invention on 8/14/1 interview on 8/14/1	fall investigation. 11:30 P.M. a direct care resident sitting on the flod alarm had sounded. To the tried to crawl to his/hat the foot of the bed. On Checklist dated 7/28/nt had a history of falls, sin place such as a bed/cosition with a fall mat. Farmaintain resident within 2/13 at 2:17 P.M. revealed by positioned bed, a call mat in place. 3/13 at 7:13 A.M. revealed by positioned bed, a call mat on the floor by the betached to the resident. 3/13 at 9:12 A.M. revealed TV room in a wheel chair at 2:07 P.M. with direct charge nurse initiated the with falls. 3 at 4:32 P.M. with licensed nursing staff initiated restigation form with falls.	or on he er 13 safety hair site at lilight ed the light ed, ed the r with t care fall sed and . sed	F 323				
	OVIDER OR SUPPLIER SUMMARY (EACH DEFICIE REGULATORY OF THE SUMMARY) (EACH DEFICIE REGULATORY OF THE SUMMARY) Continued From particular documentation of a summer found the summ	OVIDER OR SUPPLIER N GARDENS OF PRAIRIE VILLAGE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY I REGULATORY OR LSC IDENTIFYING INFORMA) Continued From page 29 documentation of a fall investigation. The NN 7/24/13 at 11:30 P.M. a direct care member found the resident sitting on the flothe fall mat. The bed alarm had sounded. The resident stated she/he tried to crawl to his/h wheelchair located at the foot of the bed. The Fall Investigation Checklist dated 7/28/revealed the resident had a history of falls, sinterventions were in place such as a bed/ci alarm, bed in low position with a fall mat. Faintervention was to maintain resident within all times. Observation on 8/12/13 at 2:17 P.M. revealer resident layed in a low positioned bed, a call was within reach and a fall mat in place. Observation on 8/13/13 at 7:13 A.M. revealer resident slept in a low positioned bed, a call within reach, a fall mat on the floor by the brand a bed alarm attached to the resident. Observation on 8/13/13 at 9:12 A.M. revealer resident sat in the TV room in a wheel chair a chair alarm on. Interview on 8/14/13 at 2:07 P.M. with direct staff W stated the charge nurse initiated the investigation forms with falls. Interview on 8/13/13 at 4:32 P.M. with licens nursing staff H stated nursing staff initiated completed a fall investigation form with falls. Interview on 8/14/13 at 9:16 A.M. with licens nursing staff J stated nursing staff initiated a investigation form for witnessed or unwitnessed or unwitnessed investigation form for witnessed or unwitnessed in unwitnessed in unwitnessed or unwitnessed in unwitn	OVIDER OR SUPPLIER N GARDENS OF PRAIRIE VILLAGE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 29 documentation of a fall investigation. The NN 7/24/13 at 11:30 P.M. a direct care staff member found the resident sitting on the floor on the fall mat. The bed alarm had sounded. The resident stated she/he tried to crawl to his/her wheelchair located at the foot of the bed. The Fall Investigation Checklist dated 7/28/13 revealed the resident had a history of falls, safety interventions were in place such as a bed/chair alarm, bed in low position with a fall mat. Fall intervention was to maintain resident within site at all times. Observation on 8/12/13 at 2:17 P.M. revealed the resident layed in a low positioned bed, a call light was within reach and a fall mat in place. Observation on 8/13/13 at 7:13 A.M. revealed the resident slept in a low positioned bed, a call light within reach, a fall mat on the floor by the bed, and a bed alarm attached to the resident. Observation on 8/13/13 at 9:12 A.M. revealed the resident sat in the TV room in a wheel chair with a chair alarm on. Interview on 8/14/13 at 2:07 P.M. with direct care staff W stated the charge nurse initiated the fall investigation forms with falls. Interview on 8/13/13 at 4:32 P.M. with licensed nursing staff H stated nursing staff initiated and completed a fall investigation form with ressed nursing staff J stated nursing staff initiated a fall investigation form for witnessed or unwitnessed	OVIDER OR SUPPLIER N GARDENS OF PRAIRIE VILLAGE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL AGE, K REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 29 documentation of a fall investigation. The NN 7/24/13 at 11:30 P.M. a direct care staff member found the resident sitting on the floor on the fall mat. The bed alarm had sounded. The resident stated she/he tried to crawl to his/her wheelchair located at the foot of the bed. The Fall Investigation Checklist dated 7/28/13 revealed the resident had a history of falls, safety interventions were in place such as a bed/chair alarm, bed in low position with a fall mat. Fall intervention was to maintain resident within site at all times. 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Interview on 8/14/13 at 9:16 A.M. with licensed nursing staff J stated nursing staff initiated a fall investigation form for witnessed or unwitnessed	OVIDER OR SUPPLIER N GARDENS OF PRAIRIE VILLAGE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LESC IDENTIFYING INFORMATION) COntinued From page 29 documentation of a fall investigation. The NN 7/24/13 at 11:30 P.M. a direct care staff member found the resident slitting on the floor on the fall mat. The bed alarm had sounded. The resident stated she/he tried to crawl to his/her wheelchair located at the foot of the bed. The Fall Investigation Checklist dated 7/28/13 revealed the resident had a history of falls, safety interventions were in place such as a bed/chair alarm, bed in low positioned bed, a call light was within reach, a fall mat on the floor by the bed, and a bed alarm attached to the resident. 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Interview on 8/14/13 at 2:16 A.M. with licensed nursing staff h stated nursing staff initiated and completed a fall investigation form for witnessed or unwitnessed or u	OVIDER OR SUPPLIER 175499 STREET ADDRESS, CITY, STATE, ZIP CODE 7105 MISSION ROAD PRAIRE VILLAGE SUMMARY STATEMENT OF DEPOSIQUIES (RACH CORRECTION) REGULATORY OR LSC IDENTIFYING INFORMATION) TAG COntinued From page 29 documentation of a fall investigation. The NN 7/24/13 at 11:30 P.M. a direct care staff member found the resident stated as history of falls, safety interventions were in place such as a bed/chair alarm, bed in low position with a fall mat. Fall intervention was to maintain resident within site at all times. Observation on 8/13/13 at 2:17 P.M. revealed the resident slept in a low positioned bed, a call light was within reach and a fall mat in place. Observation on 8/13/13 at 7:12 A.M. revealed the resident slated to the resident. Observation on 8/14/13 at 2:07 P.M. with direct care staff within reach, a fall mat on the floor by the bed, and a bed alarm attached to the resident. Observation on 8/13/13 at 2:12 A.M. revealed the resident slated to the resident. Observation on 8/13/13 at 9.16 A.M. with licensed nursing staff initiated and completed a fall investigation form with falls. Interview on 8/13/13 at 3:16 A.M. with licensed nursing staff initiated and completed a fall investigation form or withessed or unwithressed.	

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· · · ·		(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER	VCLIA		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	175499			B. WING		08/16/2013	
	OVIDER OR SUPPLIER N GARDENS OF PRA	IRIE VILLAGE	7105 MI	RESS, CITY, STA SSION ROA E VILLAGE,	.D		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY F R LSC IDENTIFYING INFORMAT	ULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION	
F 323	Continued From pag	e 30		F 323			
	only the fall investigated 5/11/13 and 7/24/13.	g staff D stated she/he tion forms for the falls o	of				
	The facility failed to provide a Fall Investigation policy and procedure.		ion				
	-	assess and investigate f cognitively impaired mo					
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem.			F 325			
			els,				
	The facility identified The sample included were reviewed for nu observation, record re	eview and interview, the ent weight loss for one (ts. 3				

FORM CMS-2567(02-99) Previous Versions Obsolete

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		' '	(X3) DATE SURVEY COMPLETED	
175499		175499		B. WING		08/16/2013		
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	RESS, CITY, STA	TE, ZIP CODE			
BRIGHTO	N GARDENS OF PRA	IRIE VILLAGE		SSION ROA				
			PRAIRII	E VILLAGE,	KS 66208			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY F LSC IDENTIFYING INFORMAT	ULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE	
F 325	- The August 2013 President #70 documed dementia with psycholdisorder characterized confusion with any macharacterized by a gratesting), pureed diet was cup (a nutrition twice a day, and hosp dementia. The telephone ordered the resident was admunit from the assisted. The Significant Changed dated 5/1/13 revealed Status score of 1 (less impaired cognition), a limited assistance of the Care Area Assess for cognition documents aff to help with deciranticipate this resider made his/her basic new The CAA dated 5/3/12 potential did not trigger. The care plan for this nutrition documented assistance with eating put syrup/honey on for interested in food. On receive two magic cup intervention was added to the control of the country of th	hysician's Order Sheet nted a diagnosis of pois (a progressive mend by failing memory and ajor mental disorder coss impairment in realitivith spoon thick liquids, hally enhanced ice creatice services for end standard dated 4/24/13 reveal itted to the long term calliving unit. The Minimum Data Set 3 dia Brief Interview for Mister and the resident require one person with eating. The sament (CAA) dated 5/3 anted this resident needs ions daily for safety, and the seds as he/she one peds known at times. The sident dated 4/24/13 reveal interview for Mister and the resident require one person with eating. The sament (CAA) dated 5/3 anted this resident needs ions daily for safety, and the seds as he/she one peds known at times.	atal d d d d d d d d d d d d d d d d d d d	F 325				

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(X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING _ COMPLETED 175499 B. WING 08/16/2013 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **BRIGHTON GARDENS OF PRAIRIE VILLAGE** 7105 MISSION ROAD PRAIRIE VILLAGE, KS 66208 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID COMPLETION PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 325 F 325 Continued From page 32 The 5/8/13 dietician progress note documented the resident received a pureed honey thick liquid diet with a magic cup two times a day. Review of 2013 weight logs documented: April - 92 pounds (lbs), May - 89 lbs June - 85 lbs July - 79 lbs - consisting of a 14.1 percent weight loss in 3 months. August - 78 lbs The dietician's progress note dated 5/8/13 recommended adding a medication as an appetite stimulant. A dietary recommendation was signed by the physician on 5/24/13 for an appetite stimulation. The telephone order revealed the Remeron (a medication used as an appetite stimulant) was not ordered until 5/31/13. A physician's order noted on 5/30/13 to increase the Magic cups to two cups with lunch and dinner. A physician's order dated 6/5/13 noted to discontinue the Remeron without a reason documented. The dietician's progress note dated 6/12/13 noted the resident received a magic cup twice a day and Ensure pudding (a nutritionally enhanced pudding) twice a day. The dietician's progress note dated 7/10/13 noted the resident still received a magic cup twice a day. There were a few medications in place, so the pudding was not added to the medication times.

, ,		` ,	(1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		175499		B. WING		08/1	6/2013	
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	ESS, CITY, STA	TE, ZIP CODE			
BRIGHTO	N GARDENS OF PRA	IRIE VILLAGE		SSION ROA VILLAGE,				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY F LSC IDENTIFYING INFORMAT	ULL	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 325	Continued From page	e 33		F 325				
	The dietician's progress note dated 7/17/13 noted the resident's diet was changed to pureed with pudding thick liquids.							
	The dietician's progress note dated 7/19/13 requested a weight recheck. The recheck was comparable to the weight obtained earlier in July. It noted the resident continued on a pureed diet with pudding thick liquids and a magic cup twice daily. It recommended the resident received							
	super cereal (nutritionally enhance oatmeal or cream of wheat) with breakfast.							
	A physician's order was received on 7/20/13 for super cereal with breakfast for this resident.							
	The dietician's progress note dated 7/31/13 revealed the resident continued on a pureed diet with pudding thick liquids and a magic cup twice daily.							
	The dietician's progress note dated 8/13/13 revealed the resident continued on a pureed diet with pudding thick liquids, super cereal, and a plate guard. It was recommended at this time to discontinue the use of the plate guard due to the resident no longer needed it.		a e to					
	Medication Administration documented the residueven though the 5/30.	June 2013, and July 20 ation Records (MARs) lent received a magic of /13 physician's order cups to 2 cups 2 times	eup,					
	diet card revealed this	2:45 P.M. of this reside s resident was suppose vith lunch and dinner, b ny magic cups.	ed to					

Printed: 08/16/2013 FORM APPROVED OMB NO. 0938-0391

(X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING _ COMPLETED 175499 B. WING 08/16/2013 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **BRIGHTON GARDENS OF PRAIRIE VILLAGE** 7105 MISSION ROAD PRAIRIE VILLAGE, KS 66208 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 325 F 325 Continued From page 34 Observation on 8/13/13 at 12:25 P.M. staff served the resident one unopened magic cup. The resident attempted to open the magic cup unsuccessfully. At 12:33 P.M. the staff served orange juice, water, pureed chili, pureed potatoes, pureed broccoli and cheese, and pureed cornbread. Staff assisted the resident to eat. The resident only consumed bites of the meal. Syrup/Honey was not added to the resident's food as planned. Staff did not attempt to offer the magic cup to the resident and the magic cup was left uneaten. Interview on 8/13/13 at 1:45 P.M. direct care staff Q stated this resident could feed himself/herself. He/she said staff should feed this resident if needed. He/she stated staff should give nutritional supplements before attempting other foods. Interview on 8/14/13 at 9:30 A.M. licensed nursing staff J stated this resident required cuing and would sometimes feed himself/herself. Licensed nursing staff were responsible for ensuring the residents consumed their ordered nutritional supplements. Dietary staff were responsible for serving nutritional supplements. Interview on 8/14/13 at 2:30 P.M. direct care staff S stated if a resident should receive a nutritional supplement, it was written on their diet card. Dietary consultant JJ on 8/16/13 at 12:08 P.M. stated he/she followed up on the resident's weight and if a decrease noted he/she would review the telephone orders to see if his/her recommendations were followed. The consultant stated the resident did not always eat and had behaviors at time. He/she also stated the resident liked chocolate would eat that.

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMB				E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	175499			B. WING		08/16/2013
NAME OF PROVIDER OR SUPPLIER BRIGHTON GARDENS OF PRAIRIE VILLAGE			7105 MIS	ESS, CITY, STAT SSION ROAD VILLAGE, P		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY F R LSC IDENTIFYING INFORMAT	ULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE COMPLETION
F 325	Continued From pag	je 35		F 325		
		ouse Supplements" upd ess administration of m provide nutritional				
	supplements as orde weight loss.	red for this resident wit	h			
	483.25(I) DRUG REC UNNECESSARY DR	GIMEN IS FREE FROM RUGS		F 329		
	Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.					
	Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.		nts not ition I			
	The facility identified	not met as evidenced by a census of 33 residents for medicar	ts.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING COMPLET	
175499 B. WING 08/1	6/2013
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
BRIGHTON GARDENS OF PRAIRIE VILLAGE 7105 MISSION ROAD PRAIRIE VILLAGE, KS 66208	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
Based on observation, record review and interview, the facility failed to monitor one resident (#70) for black boxed warnings, monitor one resident (#26) for behaviors, monitor the effectiveness of the medication for one resident (#46), and investigate potential causes for one resident's (#31) behaviors. Findings included: - The August 2013 Physician's Order Sheet for resident #70 documented a diagnosis of dementia with psychosis (a progressive mental disorder characterized by failing memory and confusion with any major mental disorder characterized by a gross impairment in reality testingjand noted an order for Depakote (a medication used to stabilize mood). The Significant Change Minimum Data Set 3.0 dated 5/1/13 revealed a Brief Interview for Mental Status score of 1 (less than 7 indicated severely impaired cognition). It documented this resident required limited assistance of one person with eating. The Care Area Assessment dated 5/3/13 for cognition documented this resident needed staff to help with decisions daily for safety, and to anticipate this resident's needs as he/she only made his/her basic needs known at times. The care plan dated 4/24/13 for medications with black boxed warnings failed to list Depakote. Lexi-Comp's Drug Information Handbook for Nursing, 12 th Edition, noted the following Black Box Warning for Depakote: Hepatic (liver) failure resulting in I fatalities (deaths) and cases of life-threatening pancreatitis (inflammation of the	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		` ′	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		175499		B. WING		08/1	6/2013	
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	RESS, CITY, STA	TE, ZIP CODE			
BRIGHTO	N GARDENS OF PRA	IRIE VILLAGE		SSION ROA E VILLAGE,				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY F LSC IDENTIFYING INFORMAT	ULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO' DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 329	Continued From page	e 37		F 329				
	pancrease) have occurred in patients. Observation on 8/13/13 at 8:15 A.M. the resident sat in a chair. He/she was alert and calm.							
	Interview on 8/14/13 a nursing staff J stated for updating the care	the nurses were respon	nsible					
	The facility policy "Skilled Nursing Standards of Performance Anti-Psychotic/Psychoactive Utilization Management" undated documented the care plan should "establish approaches for ongoing monitor for side effects of anti-psychotic medications". The facility failed to monitor for black boxed warnings for Depakote for this resident. - The August 2013 Physician's Order Sheet for resident #46 documented a diagnosis of hypothyroidism (condition characterized by decreased activity of the thyroid gland). It noted an order for Levothyroxine (a medication used to improve thyroid gland function).							
		orders noted staff sho lating hormone (TSH) I eived Levothyroxine.	I					
	5/26/13 revealed a Br	im Data Set 3.0 dated rief Interview for Mental s than 7 indicated seve	I					
	cognition revealed this memory deficits. He/s times 1 with poor reca	sment dated 2/26/13 for sesident had cognitive the was alert and orient all. Staff should provide that cues and reminders	e and ted					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE			LE CONSTRUCTION	(X3) DATE SURY COMPLETE	
		175499		B. WING		08/16	5/2013
NAME OF PR	OVIDER OR SUPPLIER	•	STREET ADDR	RESS, CITY, STA	TE, ZIP CODE	•	
BRIGHTO	N GARDENS OF PRA	IRIE VILLAGE		SSION ROA E VILLAGE,			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 329	Activities of Daily Livi him/her to group activities stimulus. Lab results reported a failed to document a Observation on 8/12/participated in nail ca and calm, and conversal literation of the admittinal applicable standing of form. The facility failed to predication monitoring. The facility failed to predication monitoring. The facility failed to predication monitoring. The facility failed to predication monitoring. The facility failed to predication monitoring. Resident #31's quales Assessment (MDS) of the resident's Brief In Score of 12, which in moderately impaired documented the residual documented the residual documented the residual documented the residual assessment period a of seven day assessment period and sev	ing. Staff should encountivities for increased mer since admission on 2/1-TSH level. 13 at 2:45 P.M. the resident He/she appeared airsed with staff appropriat 9:30 A.M. licensed when staff admitted a grunse should write allorders on a telephone of provide a policy about g. Interview for the effective of this resident. Interview for Mental State dicated 6-19-13 document atterview for Mental State dicated the resident has cognition. The MDS dent displayed verbal is of the seven day and rejected care 1 to 3 ment period. The Area Assessment (Conented the resident receed by his/her physician ods of anxiety with	atal 4/13 ident lert ately. I rrder ness et 3.0 tted us d days CAA) eived and	F 329	DEFICIENC!)		
	Score of 12, which in moderately impaired documented the reside behaviors 1 to 3 days assessment period a of seven day assessment The Psychotropic Cadated 9-28-12 documedications prescribe psychiatrist, had period	dicated the resident ha cognition. The MDS dent displayed verbal s of the seven day nd rejected care 1 to 3 ment period. The Area Assessment (Conented the resident received by his/her physician ods of anxiety with zation, panic attacks, and cognition.	days CAA) eived and				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		1 1	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		175499		B. WING		08/1	6/2013	
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	RESS, CITY, STA	ATE, ZIP CODE			
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F 329	Continued From page	e 39		F 329				
	received anti-psychot increase in Buspar (a medication) dosage. became angry, anxiou at times. The resident reassurance, and rea care plan directed state a calm, quiet manner escalated easily. The resident was obsessed oxygen. The care platthe resident to call for became anxious or has received alpramedication) 0.25 milling daily and as needed franti-psychotic medication antidepressant) 10 medication in the resident with some imbehaviors. The 5-29-13 interdiscent time written documen nurses' station multiple requested his/her inhammemory problems. Stamily if the resident of psychotic behaviors, I a gerontology (elderly	The resident was impuls and was verbally about required cueing, lity orientation at times. If to speak to the reside as the resident's behave care plan documented with his/her inhalers in directed staff to reminassistance if he/she ad shortness of air. It's medications revealed as the resident (an anti-anxiety grams (mg) three times for anxiety, Seroquel (and tion) 25 mg twice daily it buspirone (and gother times daily). In the times daily is the times do the resident came to the times during the day aller and the resident has taff informed the resident continued to have the the/she would be referred to psychiatric unit.	an an alsive, usive . The ent in vior d the and and the lent's and to the and ad ent's					
		with no time written lent's family requested the resident had tempe						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	175499		B. WING		08/	6/2013
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the resident. An undated and untir between 7-27-13 and resident continued to Seroquel, became disyelled and asked for resident was hateful staff. On 8-7-13 with no time documented staff not the resident's belliger behaviors. The resident hater and breathin resident the prescriber resident did not get redocumented the resident did not get redocumented the resident aggression es. On 8-9-13 at 5:35 P.I staff obtained an order buspar dosage for him. The resident's record thoroughly investigate behavior or provided when the resident distriction on 8-12-resident sat in his/her room with other resident. Observation on 8-13-resident in the dining	med ID note entered of 7-31-13 documented to receive Buspar and sruptive at times, screathis/her inhalers. The and inappropriate toward the written, the ID note tified the resident's family rent and disruptive lent demanded his/her and treatments. Staff gaved treatments but the elief. The ID note dent had anxiety and his	he med, rd ly of ve the s/her nted ent's ors. nt's ions to ed the rity	F 329			

TAG REGULATORY OR LSC IDENTIFYING INFORMATION) F 329 Continued From page 41 On 8-13-13 at 4:08 P.M. direct care staff U stated the resident had behaviors when he/she had difficulty with breathing and the resident would yell and curse staff. Direct care staff U stated when the resident did not like 2 people entering his/her room, had a lot of behaviors and would apologize after displaying behaviors. Direct care staff Q stated the resident became anxious because he/she thought something was wrong, He/she stated the resident became anxious because he/she thought something was wrong, He/she stated the resident screamed throughout his/her showers. On 8-14-13 at 11:41 A.M. social services staff HH stated staff redirected the resident, spoke to the resident in a calm manner, provided one to one interaction, and redirected the resident. He/she acknowledged the care plan lacked the specific behaviors and interventions for the behaviors displayed. On 8-14-13 at 1:17 P.M. licensed staff J stated he/she was not certain what triggered the resident's behaviors and when the resident had a panic attack, the resident felt staff did not		OF DEFICIENCIES F CORRECTION	` '	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	' '	(X3) DATE SURVEY COMPLETED	
BRIGHTON GARDENS OF PRAIRIE VILLAGE T105 MISSION ROAD PRAIRIE VILLAGE, KS 66208 Continued From page 41 F 329 Continued From page 42 Contin			175499		B. WING		08/1	6/2013	
CASI DISCUMMARY STATEMENT OF DEFICIENCIES DISCUMPINE DISCUMPIN	NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	RESS, CITY, STA	TE, ZIP CODE	<u> </u>		
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PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) F 329 Continued From page 41 On 8-13-13 at 4:08 P.M. direct care staff U stated the resident had behaviors when he/she had difficulty with breathing and the resident would yell and curse staff. Direct care staff U stated when the resident had behaviors, staff left and came back later. On 8-14-13 at 10:14 A.M. direct care staff Q stated the resident did not like 2 people entering his/her room, had a lot of behaviors and would apologize after displaying behaviors. Direct care staff Q stated the resident became anxious because he/she thought something was wrong. He/she stated the resident became anxious because he/she thought something was wrong. He/she stated the resident he resident. He/she acknowledged the care plan lacked the specific behaviors and interventions for the behaviors displayed. On 8-14-13 at 1:17 P.M. licensed staff J stated he/she was not certain what triggered the resident had a panic attack, the resident felt staff did not				PRAIRII	E VILLAGE,	KS 66208			
On 8-13-13 at 4:08 P.M. direct care staff U stated the resident had behaviors when he/she had difficulty with breathing and the resident would yell and curse staff. Direct care staff U stated when the resident had behaviors, staff left and came back later. On 8-14-13 at 10:14 A.M. direct care staff Q stated the resident did not like 2 people entering his/her room, had a lot of behaviors and would apologize after displaying behaviors. Direct care staff Q stated the resident became anxious because he/she thought something was wrong. He/she stated the resident screamed throughout his/her showers. On 8-14-13 at 11:41 A.M. social services staff HH stated staff redirected the resident, spoke to the resident in a calm manner, provided one to one interaction, and redirected the resident. He/she acknowledged the care plan lacked the specific behaviors and interventions for the behaviors displayed. On 8-14-13 at 1:17 P.M. licensed staff J stated he/she was not certain what triggered the resident's behaviors and when the resident had a panic attack, the resident felt staff did not	PRÉFIX	(EACH DEFICIENC	CY MUST BE PRECEDED BY F	ULL	PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	SHOULD BE	COMPLETION	
the resident had behaviors when he/she had difficulty with breathing and the resident would yell and curse staff. Direct care staff U stated when the resident had behaviors, staff left and came back later. On 8-14-13 at 10:14 A.M. direct care staff Q stated the resident did not like 2 people entering his/her room, had a lot of behaviors and would apologize after displaying behaviors. Direct care staff Q stated the resident became anxious because he/she thought something was wrong. He/she stated the resident screamed throughout his/her showers. On 8-14-13 at 11:41 A.M. social services staff HH stated staff redirected the resident, spoke to the resident in a calm manner, provided one to one interaction, and redirected the resident. He/she acknowledged the care plan lacked the specific behaviors and interventions for the behaviors displayed. On 8-14-13 at 1:17 P.M. licensed staff J stated he/she was not certain what triggered the resident had a panic attack, the resident felt staff did not	F 329	Continued From page	e 41		F 329				
respond fast enough. He/she stated staff tried to re-direct the resident, did not argue with the resident and gave the resident what he/she wanted without conversation because that also upset the resident. The facility failed to investigate and provide ongoing non-pharmacological interventions for the resident's behaviors prior to and after	F 329	On 8-13-13 at 4:08 P. the resident had behadifficulty with breathin yell and curse staff. If when the resident had came back later. On 8-14-13 at 10:14 / stated the resident did his/her room, had a loapologize after displastaff Q stated the resident did his/her showers. On 8-14-13 at 11:41 / stated staff redirected resident in a calm mainteraction, and redire acknowledged the cabehaviors and interved displayed. On 8-14-13 at 1:17 P. he/she was not certain resident's behaviors apanic attack, the resident, resident and gave the wanted without converges the resident. The facility failed to intongoing non-pharmator.	a.M. direct care staff U saviors when he/she had a gand the resident wou. Direct care staff U state of behaviors, staff left and A.M. direct care staff Q do not like 2 people entered to the of behaviors and wou ying behaviors. Direct ident became anxious gother something was wrought something with the plan lacked the special staff of the dent felt staff did not he/she stated staff triding had not argue with the expectation because that a suvestigate and provide cological interventions in the staff and p	and ering uld care ng. hout aff HH the one she ciffic s ted had a ed to	F 329				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION OF CORRECTION IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING			1 1		(AS) DATE SURVET		
		175499		B. WING		08/	16/2013
NAME OF PR	OVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
BRIGHTO	N GARDENS OF PRA	IRIE VILLAGE		ISSION ROA E VILLAGE,			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY F LSC IDENTIFYING INFORMAT	ULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 329	- The unsigned Phys dated 8/3/13 for resid diagnoses of delirium disorientation and resmental or emotional rapprehension, uncert. The quarterly Minimu 6/20/13 revealed a Br Status score of 9 (mo The revised care planmood, cognition, and resident received Depanti-seizure medication mood disorder. Depandobtained monthly and the physician. The revised care planantipsychotic medication would review the resident as needed. Nursi effects and report mo the physician/psychia obtain Depakote labs The Abnormal Involum (AIMS) dated 5/9/12 rhave any abnormal in The unsigned POS dated for Depakote 125 mill 2 capsules at bedtime morning for delirium/ar Record review on 8/1	ician's Order Sheet (PC ent #26 revealed a (sudden severe confus stlessness) and anxiety eaction characterized be ainty and irrational fear m Data Set 3.0 dated rief Interview for Mental derately impaired cognition and the pakote Sprinkles (an on used for behaviors) of kote levels would be as needed, and report and the pakote Sprinkles (an on used for behaviors) of kote levels would be as needed, and report and the pakote Sprinkles (an on used for behaviors) of kote levels would be as needed, and report and dated 5/29/13 for the pakote staff would report si od and behavior change trist, and nursing staff wand monitor for toxicity and monitor for toxicity and monitor for toxicity and the revealed the resident disvoluntary movement. The pake the pake the pake the pake the pake the resident disvoluntary movement. The pake the pak	sion, (a by). lition). nory, for ted to nacist nthly de les to would // id not ders (PO) //	F 329			

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/C		` ′	TIPLE CONSTRUCTION (X3) DATI		
		175499		B. WING		08/	16/2013
	OVIDER OR SUPPLIER N GARDENS OF PRA	IRIE VILLAGE	7105 M	RESS, CITY, STA ISSION ROAI E VILLAGE, I	D	·	
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F 329	revealed documentation 7/23/13 on the night/of as a behavior and lad the resident's signs of Behavioral Monitoring behavioral medication was monitored. The Behavioral Monitoring behavioral medication was monitored. The Behavioral Monit did not identify what be used and monitored. days that lacked document behavioral medication on 8/12/resident sat quietly in finger nails were polision. Interview on 8/13/13 and nursing staff M stated on the Behavioral Model Depakote was used for behavioral medication on the Behavioral Model Interview on 8/13/13 and nursing staff H stated on the Behavioral Model Depakote when used Interview on 8/14/13 administrative nursing should document behavioral behavioral document	ring form for July 2013 ion gaps from 7/1/13 to day shifts. Anxiety was ked documentation of a fanxiety were. The grorm did not identify we the resident received foring form for August 2 pehavioral medication of the the resident received for the resident for the resident for the resident form daily whe for the resident form daily whe for the resident form. The resident received for the resident form daily whe for the received form the effect for the form the effect for the form the form the grorm when Depakote from the payoral daily on the grorm the payoral dai	listed what what what and 2013 vas 3 s. ed the r/his ed nted n fied sed sted sted sted sted sted sted ste	F 329			
F 371	483.35(i) FOOD PRO	CURE,		F 371			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONST AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		175499		B. WING		08/16/2013
	OVIDER OR SUPPLIER N GARDENS OF PRA	IRIE VILLAGE	7105 MI	SSION ROAE VILLAGE,	.D	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION
F 371 SS=F	considered satisfacto authorities; and (2) Store, prepare, dis under sanitary conditi	ERVE - SANITARY sources approved or ry by Federal, State or stribute and serve food ions		F 371		
	This Requirement is not met as evidenced by: The facility reported a census of 33 residents. Based on observation, interview, and record review, the facility failed to maintain clean dietary bussing carts for the long term care kitchenette for 1 of 1 days on survey, failed to maintain hair restraints in the main kitchen food service area, and failed to change gloves between procedures in the main kitchen.					
	three male dietary state. Two male dietary state.	3/13 at 11:15 A.M. reve aff with facial hair uncov ff wore clean ball caps to hair. Hair nets were no aps.	vered. that			
	dietary staff EE wiped her/his 3/4 length shin left side pocket of the digital thermometer. I remove her/his gloves sleeve. Dietary staff E with the same gloves	13 at 11:45 A.M. reveal d sweat off her/his face rt sleeves and touched upper left sleeve to sto Dietary staff EE did not s after touching the left EE pushed the kitchen of and removed the digital e left sleeve pocket and	on the ore a door			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBI		1 1	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		175499		B. WING		08/16/2013	
	OVIDER OR SUPPLIER	NIDIE VIII I AGE		ESS, CITY, STAT			
ВКІСНІС	N GARDENS OF PRA	AIRIE VILLAGE		SSION ROAD E VILLAGE, P			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 45		ULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE COMPLETION	
F 371	tempted salads. Dief individual salad bow gloves. Dietary staff kitchen and removed hands Interview on 8/14/13 DD stated she/he wa and procedure was rand dietary staff EE her/his gloves after to the line of th	tary staff EE touched and while wearing the same EE then returned to the digloves and washed he at 10:50 A.M. dietary stars not sure what the polar garding hair and beard outhing her/his sleeve. at 4:00 P.M. dietary startith facial hair 1/4 to 1/2 to wear a beard net, a strator informed her/him to wear in the kitchen a land procedure titled Per 108 revealed dietary startith at or other hair restraints to appropriately restred. Beards or any body livered. Hands must always and after tary items. Clothing must recautions must be followed the followed and liquid stains. at 10:50 A.M. with dietars should clean the food come a daily cleaning buties date revealed the staff should illy Cleaning Duties date revealed the staff should illy Cleaning Duties date revealed the staff should illy Cleaning Duties date	e main br/his taff icy d nets ove aff FF inch and the rea. sonal ff at in ained hair ays be st be owed led with ary arts. duled. d	F 371			

Printed: 08/16/2013 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE			LE CONSTRUCTION	' '	(X3) DATE SURVEY COMPLETED	
		175499		B. WING		08/1	6/2013	
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	ESS, CITY, STA	TE, ZIP CODE	<u> </u>		
BRIGHTO	N GARDENS OF PRA	IRIE VILLAGE		SSION ROA E VILLAGE,				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY F I LSC IDENTIFYING INFORMAT	ULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 371	Continued From page	e 46		F 371				
	The facility failed to prepare, distribute and serve food under sanitary conditions. 483.60(c) DRUG REGIMEN REVIEW, REPORT							
	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON		ORT	F 428				
		each resident must be ee a month by a license	d					
	the attending physicia	report any irregularities an, and the director of ports must be acted up						
	The facility identified and The sample included Based on observation interview, the facility's recognize the need to for black boxed warni (#26) for behaviors, a of the medication for the sample.	s consultant failed to o monitor one resident (ings, monitor one resident and monitor the effective	ts. tions. (#70) ent					
	Findings included:							
	(POS) for resident #7 of dementia with psyc disorder characterized confusion with any may characterized by a gratesting) and noted an medication used to st	ross impairment in realit order for Depakote (a	osis nental d					

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		175499		B. WING		08/1	6/2013	
	OVIDER OR SUPPLIER	IDIE 1/11 1 4 0 5		RESS, CITY, STA	,			
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F 428	dated 5/1/13 revealed Status score of 1 (less impaired cognition). It required limited assist eating. The Care Area Assest cognition documented to help with decisions anticipate this resider made his/her basic not black boxed warnings. The care plan dated 4 black boxed warnings. Lexi-Comp's Drug Info Nursing, 12 th Edition Box Warning for Deparesulting in fatalities (life-threatening panchease) have occurred. Review of the Drug R 5/10/13, 6/25/13, and the need to monitor the boxed warnings for D. Observation on 8/13/3 sat in a chair. He/she Interview on 8/14/13 a nursing staff J stated for updating the care. Interview on 8/14/13 a consultant AA stated staff when the resider a black boxed warning warnings were on the	If a Brief Interview for M is than 7 indicated several advance of one person with this resident required daily for safety, and to interest in the same of the same	erely lent th staff sly with sess k lident lim. ensible sing with oxed	F 428				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE			LE CONSTRUCTION	(X3) DATE SU COMPLE	
17549		175499		B. WING		08/16/2013	
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	RESS, CITY, STA	TE, ZIP CODE		
BRIGHTO	N GARDENS OF PRA	IRIE VILLAGE	7105 MI	SSION ROA	D		
			PRAIRII	E VILLAGE,	KS 66208		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 428	Continued From page	e 48		F 428			
1 720	The facility policy "Sk Performance Anti-Psy Utilization Manageme the care plan should ongoing monitor for s medications". The facility's consultaneed to monitor for bl Depakote for this resi The August 2013 President #46 document hypothyroidism (conditional decreased activity of an order for Levothyroimprove thyroid glands). The facility's standing obtain a thyroid stimulon a resident who recommended the status score of 4 (less impaired cognition). The Care Area Assess cognition revealed thimemory deficits. He/stimes 1 with poor recorrections and ver Activities of Daily Living 100 and 1	illed Nursing Standards ychotic/Psychoactive ent" undated documents "establish approaches fide effects of anti-psychot failed to recognize thack boxed warnings for dent. Thysician's Order Sheet need a diagnosis of lition characterized by the thyroid gland). It no oxine (a medication use I function).	ed for notic ne for for ted ed to uld evel erely or e and ted es with rage				
		since admission on 2/14 TSH level.	4/13				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		' '	(X3) DATE SURVEY COMPLETED	
175499		175499		B. WING		08/16/2013		
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	RESS, CITY, STA	ATE, ZIP CODE	•		
BRIGHTON GARDENS OF PRAIRIE VILLAGE				SSION ROA E VILLAGE,				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	E ACTION SHOULD BE TO THE APPROPRIATE		
F 428	Review of the Drug R 3/19/13, 4/16/13, 5/10 failed to address the resident of the participated in nail carrelation and conversed. Interview on 8/14/13 and conversed. Interview on 8/14/13 and resident, the admitting applicable standing of form. Interview on 8/14/13 are consultant AA stated with each visit. The facility failed to predication monitoring. The facility's pharmace monitor for the effectific for this resident. The unsigned Physicated 8/3/13 for resided and the effection and resident or emotional resident. The quarterly Minimus 6/20/13 revealed a Brestatus score of 9 (most of the effection). The revised care plant mood, cognition, and	legimen Reviews dated 0/13, 6/25/13, and 7/16/need to obtain a TSH left 13 at 2:45 P.M. the resire. He/she was alert an with staff appropriately at 9:30 A.M. licensed then staff admitted a grurse should write all refers on a telephone or at 3:10 P.M. pharmacy the/she reviewed lab restroyed a policy about g. By consultant failed to veness of the Levothyrous of the Levothyrous ician's Order Sheet (PC ent #26 revealed a (sudden severe confus telessness) and anxiety eaction characterized be ainty and irrational fear m Data Set 3.0 dated frief Interview for Mental derately impaired cogning at dated 6/26/13 for mendelirium revealed the	/13 evel. ident ident id . rder sults oxine OS) sion, (a by c) .	F 428				
	resident received Departi-seizure medication	pakote Sprinkles (an on used for behaviors) f	for					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X	(X3) DATE SURVEY COMPLETED	
17549		175499		B. WING			08/16/2013	
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	RESS, CITY, STA	TE, ZIP CODE	-		
BRIGHTON GARDENS OF PRAIRIE VILLAGE				SSION ROA E VILLAGE,				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OI (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD E THE APPROPRI	BE	(X5) COMPLETION DATE
F 428	mood disorder. Depal obtained monthly and the physician. The revised care plan antipsychotic medicat would review the resid and as needed. Nursi effects and report mothe physician/psychia obtain Depakote labs The Abnormal Involur (AIMS) dated 5/9/12 r have any abnormal in The unsigned POS dator Depakote 125 mill 2 capsules at bedtime morning for delirium/at Record review on 8/1 documentation of a B for June 2013 for Depakote 125 mill 2 capsules at bedtime morning for delirium/at Record review on 8/1 documentation of a B for June 2013 for Depakote 125 mill 2 capsules at bedtime morning for delirium/at documentation of a B for June 2013 for Depakote 125/13/13 on the night/cas a behavior and lact the resident's signs of Behavioral Monitoring behavioral medication was monitored for. The Behavioral Monitoring did not identify what be used and monitored.	kote levels would be as needed, and report as needed, and report a dated 5/29/13 for cion revealed the pharm dent's medications morng staff would report si od and behavior chang trist, and nursing staff wand monitor for toxicity and 125 mg PO every anxiety. 3/13 at 2:15 P.M. lacke ehavioral Monitoring for pakote used for a for for July 2013 for gaps from 7/1/13 to day shifts. Anxiety was ked documentation of verticing for the same decided and the same for the s	nacist nthly de les to would /. dd not ders (PO) / ed rm o (-) listed what chat and out 3 vas 3	F 428				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING		(X3) DATE SURVEY COMPLETED		
	175499 B. WING _			B. WING	08/16/2013			
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	ESS, CITY, STA	TE, ZIP CODE			
BRIGHTON GARDENS OF PRAIRIE VILLAGE				SSION ROA VILLAGE,				
(X4) ID PREFIX TAG	SUMMARY S (EACH DEFICIEN REGULATORY O	ULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	ILD BE CON	(X5) MPLETION DATE		
F 428	The Medication Reg 2/11/13, 3/19/13, 4/17/16/13 revealed no Observation on 8/12 resident sat quietly in finger nails were poll Interview on 8/13/13 nursing staff M state on the Behavioral McDepakote was used behavioral medication the Behavioral McDepakote when used behavioral medication the Behavioral McDepakote when used Interview on 8/13/13 nursing staff H state on the Behavioral McDepakote when used Interview on 8/14/13 administrative nursing should document be Behavioral Monitoring used for behaviors. Staff AA reviewed the Interview 8/14/13 at consultant staff AA serecords were review inform the nursing st Monitoring forms.	imen Review dated 1/14 16/13, 5/10/13, 6/25/13, irregularities. 1/13 at 3:00 P.M. revealed a wheelchair while her ished. 1/14 at 2:30 P.M. with license and dished. 1/15 at 2:30 P.M. with license and dished. 1/16 at 2:30 P.M. with license and dished. 1/17 at 3:00 P.M. with license and dished. 1/18 at 4:32 P.M. with license and dished and dished and state and	and ed the r/his sed hted in fied sed hted sof staff was ht corms. ey I would rioral	F 428				
	resident's behaviora 483.75(o)(1) QAA COMMITTEE-MEME QUARTERLY/PLAN	I medications. BERS/MEET		F 520				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE			LE CONSTRUCTION	(X3) DATE SU COMPLE	
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		170433				08/	6/2013
	OVIDER OR SUPPLIER			RESS, CITY, STA			
BRIGHTO	N GARDENS OF PRA	IRIE VILLAGE		SSION ROA E VILLAGE,			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 520	Continued From page	e 52		F 520			
	A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.						
	The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.						
	A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.						
	Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.						
	The facility identified a with 18 included in the observation, record refacility failed to have a	eview, and staff intervie a Quality Assessment a mmittee that identified	w the				
	Findings include:						
	- During an interview on 8/14/13 at approximately 5:15 P.M. Administrative Nursing Staff D reported the facility had a QAA committee that met monthly. The information from the QAA meeting was presented at the July staff meeting, and staff						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE			LE CONSTRUCTION	(X3) DATE SU COMPLET	
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		110100				00/1	0/2013
	OVIDER OR SUPPLIER	IDIE VIII I AOE		RESS, CITY, STA			
БКІВПІО	N GARDENS OF PRA	IRIE VILLAGE		SSION ROA E VILLAGE,			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF COR	RECTION	(X5)
PREFIX TAG	(EACH DEFICIENC	EY MUST BE PRECEDED BY FI LSC IDENTIFYING INFORMAT	ULL	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	COMPLETION DATE
F 520	Continued From page	e 53		F 520			
	were educated on the QAA committee. Administrative Nursing staff D had identified the nursing department needed a total revamp to keep the residents safe.						
	The facility failed to ensure the QAA committee addressed Liability notices. Please see F156 for additional information.						
	The facility failed to ensure the QAA committee addressed the residents' right to exam the survey results. Please see F167 for additional information.						
	The facility failed to ensure the QAA committee addressed the residents right to choose activities, schedules, and health care consistent with his or her interests. Please see F242 for additional information.						
	The facility failed to ensure the QAA committee addressed development of comprehensive care plans. Please see F279 for additional information.						
	The facility failed to ensure the QAA committee addressed the revision of care plans. Please see F280 for additional information.						
		nsure the QAA committ care. Please see F309					
	The facility failed to ensure the QAA committee addressed services for accidents hazards, and prevention of falls. Please see F323 for additional information.						
	The facility failed to el addressed nutrition.	nsure the QAA committ Please see F325 for	tee				

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17549		175499		B. WING		08/16/2013		
NAME OF PRO	OVIDER OR SUPPLIER		STREET ADDR	RESS, CITY, STA	TE, ZIP CODE			
BRIGHTO	N GARDENS OF PRA	IRIE VILLAGE		SSION ROA E VILLAGE,				
(X4) ID PREFIX TAG				ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 520	addressed unnecessar for additional information addressed storing, prounder sanitary conditional information. The facility failed to enaddressed pharmacy for additional information. The facility failed to enaddressed water temptor addressed water temptor additional information. The facility failed to enaddressed water temptor in the facility failed to have assurance program in the facility failed to have assurance program in the facility failed to have assurance program in the facility failed to have a surance program in	nsure the QAA committed ary drugs. Please see tion. Insure the QAA committed are the QA	tee od for tee F428	F 520				